Print

WILSON PEDIATRICS

Records Release To Wilson Pediatrics (Transfer Out)

If you have any difficulties obtaining your records, please contact our front desk staff.

Parent or Guardian:_____

Address: _____City_____St_____Zip:_____

Cell#: _____Work#_____ Home Phone#_____

Email:_____

Children's Names:

1. _____DOB: _____
2. _____DOB: _____
3. _____DOB: _____

Reason for transfer: _____

I authorize: (Name of previous physician) _____

Phone: _____Fax:_____

to release medical information from my medical record to:

Name :_____ Phone: _____

Address: _____City_____St_____Zip:_____

Email:_____

for the purpose of review/examination. I further authorize you to provide copies as requested and indicated to the limitations below:

Substance Abuse Yes: ◯ No: ◯

Psychiatric/Mental Health Information Yes: ◯ No: ◯

HIV Information Yes: ◯ No: ◯

This authorization will automatically expire on year from the date signed.

I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance thereon.

Signed:_____Date:_____

OFFICE USE ONLY

Date Received: _____Records Sent By:_____Date_____